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Subj: ACTIVE DUTY MENTAL HEALTH CONDITIONS AND EMERGENCIES

1. PURPOSE. This publication provides a reference regarding mental health conditions and emergencies for Coast Guard active duty personnel.

2. ACTION. Area and district commanders, commanders maintenance and logistics commands, commanding officers of Headquarters units, Commandant (G-A, G-H, G-L, G-M, G-O, G-S, and G-W), and special staff offices at Headquarters will ensure dissemination of the information contained herein.

3. DISCUSSION.

   a. Commanding officers, medical officers, and supervisors must be prepared to assess persons who express concerns regarding mental health or exhibit unusual behavior. These may include suicidal or homicidal ideations, hallucinations, delusions, or other behavior which is potentially harmful to the individual or to others. This publication summarizes mental health directives and is intended to assist personnel who are not mental health professionals in obtaining mental health care for active duty personnel.

   b. It is important that supervisors become familiar with the information in this publication. Good mental health keeps personnel fit for duty and operationally effective. Unresolved stressful situations, family problems or assignment adjustment concerns can interfere with quality of life and job performance. The first step towards

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resolving issues and returning to a healthy lifestyle may be asking for assistance. Personnel who require mental health evaluations and treatment must be treated with sensitivity and appropriate confidentiality. This publication outlines the various programs and the methods of obtaining mental health care.

ALAN M. STEINMAN
Director of Health and Safety

ACTIVE DUTY MENTAL HEALTH CONDITIONS AND EMERGENCIES

1. GENERAL. This publication outlines various aspects of and methods for obtaining mental health care for active duty members. It also discusses procedures for dealing with certain mental health emergencies, such as suicidal individuals. Identifying the appropriate course of action for a member presenting with a mental health condition requires a careful step-by-step process. If the member's performance is effected, a fitness for duty determination may be required.

2. FITNESS FOR DUTY.

   a. Fitness for duty determinations require the review of all pertinent factors associated with the member's condition. In this regard, the member must first receive a medical and psychological evaluation and prognosis from a military physician and a licensed clinical psychologist or psychiatrist. If a military physician is not available, the command may refer the member to a nonfederal physician for a medical evaluation and, if appropriate, a consult referral to a licensed clinical psychologist or psychiatrist to obtain an initial evaluation and treatment plan. Such an evaluation is required before any administrative action concerning a member's fitness for service is taken. (Chapter 5-B, Medical Manual COMDTINST M6000.1 (series), provides guidance regarding action diagnoses.)

   b. For conditions generally considered treatable and not grounds for immediate separation, mental health treatment may be authorized for members when medically necessary to maintain fitness for unrestricted duty. The decision to provide treatment for mental health conditions will be based on a review of all factors, including the opinion of experts, probability of a successful outcome, and the presence of other physical or mental conditions.

   c. If a successful outcome is not realized within six months of the initiation of therapy, the patient must be reassessed. If the reassessment indicates that the prognosis for a successful outcome in the near future is poor, the member must be processed for separation through the physical disability evaluations system (PDES) or Chapter 12 of the Personnel Manual, Commandant Instruction M1000.6 (series). A successful outcome is defined as the member is fit for unrestricted duty at his/her rank or rate while not requiring continued or recurrent therapy.

3. RECORDS. All records and correspondence regarding mental health care is privileged medical information and must be handled in accordance with Chapter 4-A, Coast Guard Medical Manual COMDTINST M6000.1 (series). The following records are critical to ensure that the member's case is documented and to assess the quality, appropriateness, and effectiveness of any treatment program. The mental health provider, whether Federal or nonfederal, must provide the command with the following information for inclusion in the member's health record:

   a. A copy of the initial evaluation, including the diagnosis (by DSM code, Axis 1 and Axis 2), treatment plan, and prognosis both with and without treatment;

   b. A summary of all treatment administered, and;

   c. An assessment of physical and mental capabilities and limitations (e.g., "Patient may do routine desk work but is to avoid stressful situations."). These capabilities and limitations shall be translated into corresponding work and duty limitations by the member's command (e.g., fit for limited duty - member may perform routine clerical work).

   d. If required by the provider, the command will submit a letter or release form, signed by the member, to obtain the above records.

4. AVAILABILITY OF RESOURCES.

   a. The preferred sources of mental health care for members are federal facilities, such as Coast Guard, Department of Defense (DoD), or Veterans Affairs (VA) medical treatment facilities (MTFs). Active duty members may self-refer or can be directly referred by medical personnel or their commanding officer to a federal facility. MLC (k) authorization is not required for members to seek care at an MTF.

      (1) Public Law 102-484, Section 546, also known as the "Boxer Amendment," placed certain requirements on DoD commanders when referring their members for mental health evaluations. These restrictions were implemented to prevent unwarranted mental health evaluations or involuntary hospitalization as a form of harassment or retaliation for reporting derogatory information.

      (2) The Coast Guard was not included in this legislation. Therefore, Coast Guard members who are command referred to Coast Guard, DoD, or nonfederal mental health providers are not required to present

a "written acknowledgment of rights" or a "statement of counseling with an attorney" when appearing for evaluation.

b. When mental health services are not available from federal sources, commands may request authorization of nonfederal medical care. MLC (k) is the sole approving authority for nonfederal care. **Active duty members who undergo non-emergency, nonfederal mental health care without prior approval will be responsible for all costs incurred.** Emergency mental health care (e.g., suicide intervention) may be obtained without prior approval; however, continuation of mental health care must be authorized by the appropriate MLC (k) (see paragraph 5).

c. Parenting, marital, financial, or other "life skill" counseling and behavior modification programs are not authorized as part of the Health Services Program but may be included as part of the Employee Assistance Program. (See paragraph 6.) Any questions involving funding mental health care for active duty members should be directed to the appropriate MLC (k) Health Benefits Advisor (HBA) by calling 1-800-9HBAHBA.

5. OBTAINING NONFEDERAL MENTAL HEALTH CARE.

a. Specific procedures for requesting nonemergency, nonfederal mental health care are contained in cognizant MLC (k) directives. The following provides a summary for acquisition of nonfederal care.

(1) Prior to MLC (k) approval of a request for nonfederal mental health care, the member must first receive a medical and psychological evaluation and prognosis, which will normally be provided by a physician and a licensed clinical psychologist or psychiatrist.

(2) If the initial evaluation indicates a need for immediate or continuing therapy, the command must submit a request within 72 hours to the appropriate MLC (k) for nonfederal mental health care authorization. Therapy should not be interrupted while the request is pending. If a request is denied, the cognizant MLC (k) will pay for services rendered up to the date of denial, but only if the request was initiated within 72 hours.

(3) Requests to continue therapy must be submitted to the cognizant MLC (k) and must include:

(a) Psychiatrist's or clinical psychologist's diagnosis, as coded by Diagnostic and

Statistical Manual of Mental Disorders Code (DSM-IV or most recent edition).

(b) Information regarding all prior treatment for this condition, including: provider, length of treatment, and total cost to date.

(4) Chapter 5-B, Coast Guard Medical Manual, COMDTINST M6000.1 (series), contains instructions about retention or disposition of individuals with certain diagnoses.

b. Emergency mental health care (e.g., suicide intervention) does not require prior MLC (k) approval.

6. EMPLOYEE ASSISTANCE PROGRAM.

a. The Employee Assistance Program (EAP) provides confidential counseling assessments, short-term problem solving, and referral services. Coast Guard personnel may use EAP for help with personal, family, or job related problems. EAP also addresses alcohol/drug problems, stress management, eating disorders, and excessive grief and loss. Psychologists, social workers, counselors, and therapists are available to provide these services.

b. Services provided through EAP are strictly confidential, except for command referrals for evaluation. Information shared with the EAP counselor will not be disclosed without the written consent of the person receiving the assessment or counseling.

c. When Coast Guard personnel feel they need assistance they may call 1-800-523-5668, 24 hours a day. When the 800 number is answered, the receptionist will need the following information:

(1) name, place of employment and location;
(2) general nature of caller's concern;
(3) phone number where caller can be reached; and
(4) general location of where caller would like to see a counselor.

An assessment counselor will return the call within 24-48 hours to arrange a convenient time to meet in person. Although the EAP should not be seen as an emergency service, immediate telephone support is provided to personnel experiencing an urgent need to speak with a counselor.

d. EAP assistance is limited to three to six visits to assess a particular problem or complaint. The EAP

counselor will work with the member to identify the problem and develop a course of action. There is no fee associated with these assistance visits. Many personnel find that the EAP assessment process provides resolution of their concern.

e. The Coast Guard EAP is the responsibility of the Work-Life Program. Questions regarding EAP should be addressed through the cognizant Work-Life Staff, or by calling 1-800-523-5668.

7. MENTAL HEALTH EMERGENCIES. Any member may be called upon to handle a suicide attempt or other mental health emergency. Personnel can report with suicidal thoughts or behavior, or other behavior potentially harmful to self or others, such as homicidal ideation, hallucinations, or delusions. It is essential that the identification and management of members with suicidal ideation or behavior be carefully conducted. This section will discuss various emergencies and their management.

a. Suicide prevention program. Specific provisions of the Coast Guard suicide prevention program are to be published in a separate Commandant Instruction. An additional reference for health services personnel may be found in Quality Assurance Implementation Guide (QAIG) No. 4, promulgated in February 1990.

b. Identification of suicidal individuals.

(1) Identification of personnel at risk is the basis of any program seeking to prevent suicides. Newly transferred personnel living alone and separated from the usual family and emotional support as well as those with financial, marital, or career difficulties are at particular risk.

(2) The recognition of a suicidal person is cause for intervention by whomever makes that recognition. Talk of death, wishing to be reunited with deceased relatives, giving away significant personal items, and/or making a will at a seemingly inappropriate time should be cause for concern.

(3) Direct inquiry is an appropriate means of screening for suicide potential, even if it is limited to a simple "How are you managing emotionally?" or "Are you discouraged about how things are going?" or "Do you think you can handle [a certain situation] ok?" If the response is not reassuring, the individual should be further questioned about suicide, "Does it get so bad that you think it is not worth going on--that you think about suicide?" Any positive

response is cause for alerting local health and/or command authorities.

(4) Intervention to prevent a suicide attempt must begin at the first recognition that an individual is at risk. Intervention ranges from simply referring the individual to appropriate support personnel, to specific treatment from professional providers. The degree of intervention depends on the knowledge, skills, and abilities of the individual intervening and his or her assessment of the situation. However, under no circumstances should someone feel that there is "nothing more to be done" when the threat of suicide remains.

c. Suicide threats.

(1) A suicide threat is an act, statement or pattern of statements which reveal that the individual is intending to harm himself or herself in such a manner as to cause self-induced death. All suicide threats should be considered authentic, and immediate intervention begun.

(2) A telephone checklist should be available to personnel who might receive a telephone call concerning a suicide threat, to assist them in tactfully obtaining critical information. An example of such a checklist is included as enclosure (1).

(3) When the basic information is obtained, it should be given to another person who can notify law enforcement, command, or medical personnel while the initial person maintains contact with the caller in order to keep him/her occupied until help can arrive.

(4) When the situation involves military personnel, security (if available) has the responsibility to notify the officer of the day (OOD), who will coordinate response efforts.

(5) At units with medical officers assigned, all threats must be reported to a medical officer, or in his/her absence, the clinic administrator.

d. Suicide attempts.

(1) A suicide attempt is an intentional act, causing physical self-harm, where death will occur without intervention. Suicide is a needless loss of life and is almost always preventable. Precipitating

factors are generally temporary, having developed over a relatively short period of time.

(2) In the event of a suicide attempt, the first priority is the treatment of injuries or other medical problems involved. Life-threatening trauma or ingestion requires that the person be transported to the nearest emergency room as soon as medically appropriate.

e. Transportation. In the case of an emergency, or if the member requires physical or chemical restraint (sedation), an ambulance or other appropriate vehicle should be used. During transportation, the member should be monitored by someone other than the driver. Prior to transporting, ensure the following actions have been completed:

(1) The patient is medically stabilized.

(2) An attendant, preferably an HS or the civilian equivalent, is assigned to monitor the patient closely during transportation. The patient is not to be left unattended at any time (this includes during medical/surgical stabilization procedures). Medical officer judgment (via telephone contact if not otherwise available) determines the need for a medical officer or additional attendants to accompany the patient during transport. Examples include patients who might require medications or respiratory support en route.

(3) Treatment and complications are documented. A medical officer or civilian physician must make any determinations regarding the use of mechanical or chemical restraint and may order such only to protect the patient from injuring himself, herself, or others. Restraint is not to be used as a form of punishment or for the convenience of the staff. Orders for restraint are to include the provider's evaluation of the patient, the patient's mental status, a description of behavior leading to restraint, a description of other methods of behavior modification which were attempted, and a description of behavior which would allow removal of the restraints. It is essential that the patient's physical condition be evaluated with regard to the need for other forms of medical attention. After restraints are applied, the provider must ensure they have been properly applied and reevaluate the patient at frequent intervals with regard to circulatory status, blood pressure, mental status, respiratory status, etc. Law enforcement and

civilian ambulance crews may use their own protocols for restraints.

f. Other mental health emergencies or situations.

(1) The procedures for handling other mental health emergencies are similar to those presented above. Patients who are acting out, who are suffering from delusions or hallucinations, or who have sustained an injury, may require medical stabilization prior to transport.

(2) Occasionally members are seen who are threatening, disruptive, or destructive but who do not have symptoms or signs of mental illness, such as psychosis, delirium, or dementia. In such cases, follow the appropriate administrative and/or disciplinary measures.

8. EATING DISORDERS.

a. The term eating disorder covers a collection of disturbances in eating behavior exclusive of simple overeating. Conditions of importance to the Coast Guard include anorexia nervosa and bulimia nervosa. Symptoms range in severity from mild to life threatening. These disorders are most frequently seen in young women, though they can also be seen in men. The potential for adverse effects on health and well-being necessitates timely and appropriate intervention.

(1) Anorexia nervosa is characterized by intense fear of gaining weight, distorted body image, cessation of menses, and prolonged refusal to maintain adequate weight despite being underweight for age, height, and sex.

(2) Features of bulimia nervosa include recurrent episodes of binge eating, excessive concern about weight, and overly aggressive methods to lose weight such as post eating vomiting and use of laxatives.

b. Eating disorders have a potential to affect fitness for duty, but the diagnosis of an eating disorder does not automatically mean the member is unsuitable for continued service.

c. Individuals suspected of having an eating disorder shall be referred for evaluation by a professional with psychiatric or clinical psychology training relevant to eating disorders. Treatment may be authorized in accordance with the same criteria as other mental health conditions.

9. POSTTRAUMATIC STRESS DISORDER AND ADULT ATTENTION DEFICIT DISORDER.

a. Posttraumatic stress disorder (PTSD).

(1) PTSD refers to the constellation symptoms that may result in an individual after being exposed to a severe, life-threatening stressor. The three major features of PTSD include:

(a) the reexperiencing of the traumatic event through dreams or waking thoughts,

(b) an emotional numbing to other life experiences that was not present prior to the trauma, and

(c) symptoms of autonomic arousal, depression, and cognitive difficulties (e.g., inability to concentrate). Together, these disturbances cause clinically significant distress or impairment of normal life.

(2) PTSD usually presents within six months of the precipitating stressful event; however, onset may be delayed for years. Symptoms can fluctuate over time and may be most intense during periods of stress. Approximately 30 percent of patients recover completely, 40 percent continue to have mild symptoms which do not interfere with functioning, 20 percent continue to have moderate symptoms, and up to 10 percent fail to recover. A good prognosis is predicted by a rapid onset of symptoms, short duration of symptoms, good functioning prior to onset, strong social supports, and the absence of other medical or psychiatric problems.

(3) Individuals suspected of having PTSD shall be referred for evaluation. Treatment may be authorized in accordance with the same criteria as other mental health conditions.

b. Adult Attention Deficit Disorder (AADD).

(1) AADD is not currently recognized as a separate or distinctive clinical syndrome by the American Psychiatric Association in DSM-IV. Some mental health providers contend that individuals with AADD have a mild case of unspecified Attention Deficit/Hyperactivity Disorder (AD/HD), which was not diagnosed earlier because they were able to function normally through childhood and adolescence. The long-term prognosis of individuals diagnosed with AADD has not been established. There are no

laboratory tests that have been found to be diagnostic of AD/HD or AADD, and the diagnosis is strictly based on clinical symptoms and performance factors.

(2) Extended or continuing treatment for AADD alone will generally not be provided. In addition, members with disorders of intelligence that interfere with satisfactory performance of duty may be evaluated for service suitability and may be administratively separated. See Chapter 5-B of the Coast Guard Medical Manual COMDTINST M6000.1 (series).

SAMPLE CHECKLIST FOR TELEPHONIC SUICIDE THREATS

If you receive a suicide threat on the telephone, you should attempt to **keep the caller on the line** and obtain the following information.

WHO IS CALLING? _____

WHERE CALLING FROM? _____

_____

If the caller will not answer, listen for clues from background sounds.

CALLER'S PHONE NO.? _____

WHAT IS THE DIFFICULTY? LET'S TALK ABOUT YOUR PROBLEM. I THINK I CAN HELP YOU. _____

_____

ARE YOU GOING TO INJURE YOURSELF? _____

HOW? _____

WILL ANYONE ELSE GET INJURED? _____

When you have the necessary information, **activate emergency response** (call 911 or follow local protocol). If possible, send someone else with all of the above information to activate the response, while continuing to talk to the caller on the first line. If you had to hang up to activate emergency response, call the person making the suicide threat back.

Keep talking until help arrives or as long as possible. Show you care by talking with the individual; let him/her tell you his/her true feelings and let him/her tell you about the difficulties he/she is having. **THINGS TO TALK ABOUT: Family, friends, girlfriend/boyfriend, parents, job, hobbies, where caller lives, where caller grew up, where caller has been assigned in past.**

<u>PHONE NUMBERS</u>

EMERGENCY SERVICES: _____

LOCAL AREA SUICIDE HOTLINE: _____